SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40172*
Company Tracking Number:			
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Evaluation Services Amendment and Group Application Form	SERFF Tr Num: UHLC-125804183	State: ArkansasLH
TOI: H07G Group Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 40172
Sub-TOI: H07G.001 Critical Illness	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Tracy Slaughter	Disposition Date: 09/08/2008
	Date Submitted: 09/04/2008	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2009		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 09/08/2008	
State Status Changed: 09/08/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Form Numbers: UCC-POL-Amend Evaluation-AR & UHICMTP APP (8/08)

Evaluation Services Amendment and Group Application Form.

SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
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Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Please see Cover Letter under Supporting Documentation for additional details.

Company and Contact

Filing Contact Information

Tracy Slaughter, Contract Specialist
5901 Lincoln Dr
Edina, MN 55436

tslaughter_uhc.com
(952) 992-5438 [Phone]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707

Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Health

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	2 forms @ $20 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$40.00	09/04/2008	22297262

SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/08/2008	09/08/2008

SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40172*
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Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/08/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40172*
Company Tracking Number:			
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Compare Document	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Group Application Form	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-125804183*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40172*
Company Tracking Number:			
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Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: UCC-POL-Amend Evaluation

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UCC-POL-Amend Evaluation-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		55	Eval AmendmentAR.pdf
Approved-Closed	UHICMTPAPP (8/08)	Application/Enrollment Form	Group Application Form	Initial		47	Group Application.pdf

United HealthCare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut

(Home Office)

Policyholder: [XXXX] **Policy Number: [XXXXXX]**

This Amendment/Rider, effective [XXXX, 1, 2009], amends the Policy/Certificate of Coverage as follows:

The Maximum Transplant Evaluation Benefit as described under the Schedule of Benefits is replaced with the following:

Benefit	Network	Non-Network
Maximum Transplant Evaluation Benefit	[90 -100]% of Eligible Expenses	[50-80]% of Eligible Expenses [up to a maximum of $[10,000-20,000]].

All other provisions of the Policy/Certificate of Coverage remain unchanged.

[Thomas J. McGuire
Deputy General Counsel]

United HealthCare Insurance Company
APPLICATION FOR TRANSPLANT INSURANCE

The undersigned Applicant requests the Transplant Insurance Benefits shown herein and provided by United Healthcare Insurance Company, and agrees to be bound by the terms and provisions of the Transplant Insurance Policy.

Section 1: APPLICANT INFORMATION

Full Legal Name of Applicant: _____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____ **Tax ID Number** _____

Contact Person: _____
Telephone No: _____ **Fax No.** _____
Email Address: _____

Total number of eligible persons: _____ **Total number of covered persons:** _____

Requested Effective Date: _____ **First Renewal Date**: _____

Company is: ☐ Corporate ☐ Partnership ☐ Trust ☐ Association
Company is: ☐ ERISA ☐ ERISA exempt plan **ERISA Health Plan Number:** _____

Section 2: PLAN ADMINISTRATOR / TPA

Name of Plan Administrator / TPA: _____
Address: _____
City: _____ **State**: _____ **Zip**: _____
Phone: _____

Contact Name: _____
Phone: _____ **Email Address:** _____

Financial / Accounts Payable Contact Name: _____
Phone: _____ **Email Address:** _____

Section 3: CASE MANAGEMENT

Case Management Company: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Contact Name: _____
Phone: _____ **Email Address:** _____

Section 4: ELIGIBILITY INFORMATION

Employee Waiting Period Options ☐ First of the month following _____days of employment. ☐ Other:_____.

To be eligible, Employee must work _____ or more hours per week, and must be actively at work on the effective date of insurance. If not actively at work, insurance will be effective on the first day of the month following return to active employment.

Dependent Age Requirements: Birth to _____ or _____ if full-time student.

Dependent Termination: ☐ Date Dependent attains age limit; ☐ End of calendar year Dependent attains age limit; or ☐ Other:_____. College verification required? ☐ Yes ☐ No

Section 5: PREMIUMS

All premiums are due on the first day of the calendar month of insurance.

Initial Premium: Amount Due$_____. Amount Received $_____.

Premium Rates:

Prepaid Plan:

Employee Only:	$	Number covered:	= $
Employee + One:	$	Number covered:	= $
Employee + Spouse:	$	Number covered:	= $
Employee + Children:	$	Number covered:	= $
Employee + Family:	$	Number covered:	= $
Composite:	$	Number covered:	= $

TOTAL MONTHLY PREMIUM: = $_____

It is understood and agreed that the Transplant Insurance will become effective on the date requested only if this Application is accepted. The Applicant agrees to transmit the total premiums for this insurance to United Healthcare Insurance Company when due. The Applicant declares to the best of its knowledge and belief that statements and answers on this Application are complete and true.

Date: _____

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____

Name of Broker Firm: _____

Signature of Agent or Broker: _____

Print Full Name: _____

Agent Address: _____

City: _____ State: _____ Zip: _____

Agent's Telephone No.: _____ Agent's Fax No.: _____ License No._____

Send completed Application with binder check to:

United HealthCare Insurance Company
OptumHealth Care Solutions
6300 Olson Memorial Highway
MN010-E169
Minneapolis, MN 55427-4961

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Arkansas and Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

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Product Name:	*Evaluation Services Amendment and Group Application Form*		
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Rate Information

Rate data does NOT apply to filing.

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Product Name:	*Evaluation Services Amendment and Group Application Form*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	09/08/2008

Comments:

Attachment:

ARFlesch.pdf

		Review Status:	
Bypassed -Name:	Application	Approved-Closed	09/08/2008

Bypass Reason: Group Application is being filed and is included under the Forms tab

Comments:

		Review Status:	
Satisfied -Name:	Cover Letter	Approved-Closed	09/08/2008

Comments:

Attachment:

Cover Letter.pdf

		Review Status:	
Satisfied -Name:	Compare Document	Approved-Closed	09/08/2008

Comments:

Compare document displays changes made to the Evaluation Services section by the filed Amendment Form.

Attachment:

WS_BinaryComparison_Maximum Evaluation Benefit OLD-Maximum Evalution Benefit New.pdf

United HealthCare Insurance Company
Hartford, Connecticut
NAIC #79413

CERTIFICATION OF COMPLIANCE

This is to certify that the accompanying forms comply with your state's readability requirements:

A. **Option Selected**
The forms are scored separately for the Flesch reading ease test. Flesch Score is indicated below.

Form	Flesch Score
UCC-POL-Amend Evaluation-AR	54.7
UHICMTP APP (8/08)	47.0

B. **Test Option Selected**
Test was applied to each entire policy form.

C. **Standards for Certification**
A checked block indicates the standard has been achieved.

X 1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.

X 2. It is printed in not less than ten point type, one point leaded.

X 3. The layout and spacing of the policy forms separate the paragraphs from each other and from the border of the paper.

X 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

X 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the forms.

Thomas J. McGuire, Deputy General Counsel

Date: September 5, 2008

UnitedHealthcare®
A UnitedHealth Group Company

September 5, 2008

Rosalind Minor
Certified Rate & Form Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: **United HealthCare Insurance Company**
NAIC No. 79413
Form Numbers: UCC-POL-Amend Evaluation-AR & UHICMTP APP (8/08)
Product Matrix Coding: H07G.001

Dear Ms Minor:

On behalf of United HealthCare Insurance Company, I am submitting the enclosed group amendment form listed above for your Department's review and approval. This form is being filed for large employer groups.

The enclosed form will be used in conjunction with our previously approved policy/certificate series series UCC-POL-AR (02/04) et al., approved by your department on July 6, 2004.

The intent of this filing is to revise the Maximum Transplant Evaluation Benefit under the Schedule of Benefits. This amendment revises this section as follows:

- Removes coverage of Evaluation Benefit for services incurred prior to the effective date of the Policy.
- Removes requirement that benefits for Evaluation Services incurred on or after the Policy Effective be paid at the time of Transplant. Benefits for Evaluation Services will be paid when Benefits are incurred regardless of time of Transplant.
- Adds an option to limit Non-Network Benefit to $[10,000 - 20,000].

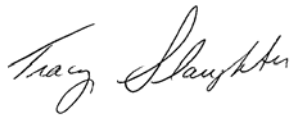
Enclosed for your reference is a compare document to enable you to view the specific changes made to this section.

Also enclosed in a new group application form for use with this product.

We would also like to reserve the right to build the amendatory language into the Policy/Certificate or leave it in the amendment format, whichever we deem most appropriate for the group.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,



Tracy Slaughter
United HealthCare Insurance Company
5901 Lincoln Drive
Edina, MN 55436
Ph: 952-992-5438/Fax: 952-992-5105
Email: tslaughter@uhc.com

Benefit	Network	Non-Network
Maximum Transplant Evaluation Benefit	~~Prior to the Policy Effective Date:~~ [90 -100]% of Eligible Expenses ~~up to a maximum of $5,000 for the evaluation reimbursed at the time of Transplant if the Covered Person is listed within 365 days prior to the date of the Transplant and the Transplant occurs during the Policy Period.~~ ~~On or after the Policy Effective Date: 100% of Eligible Expenses for the evaluation at the time of Transplant if the Covered Person is listed within 365 days prior to the date of the Transplant and the Transplant occurs during the Policy Period.~~	~~Prior to the Policy Effective Date: Not Covered.~~ [50-80]% of Eligible Expenses [up to a maximum of $[10,000-20,000]]. ~~On or after the Policy Effective Date: 60% of Eligible Expenses for the evaluation at the time of Transplant if the Covered Person is listed within 365 days prior to the date of the Transplant and the Transplant occurs during the Policy Period.~~

Document comparison by Workshare Compare on Wednesday, August 13, 2008 1:57:11 PM

Input:	
Document 1 ID	file://S:/KTEAM/SCS Files/URN Filings/2008 Generic Eval Amendment/Generic Compare/Maximum Evaluation Benefit OLD.doc
Description	Maximum Evaluation Benefit OLD
Document 2 ID	file://S:/KTEAM/SCS Files/URN Filings/2008 Generic Eval Amendment/Generic Compare/Maximum Evalution Benefit New.doc
Description	Maximum Evalution Benefit New
Rendering set	standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	3
Deletions	5
Moved from	0
Moved to	0
Style change	0
Format changed	0
Total changes	8